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Overcoming Governance and Cost Challenges for Australian Public Hospitals: The Foundation Trust Alternative

Peter Phelan and Jeremy Sammut

Papers in Health and Ageing (13)

THE CENTRE FOR INDEPENDENT STUDIES

National Library of Australia Cataloguing-in-Publication Data:

Sammut, Jeremy, 1971- author.

Overcoming governance and cost challenges for Australian public hospitals : the foundation trust alternative / Dr Jeremy Sammut.

9781922184214 (paperback)

CIS policy monographs ; PM137,

Medical policy--Australia.

Public hospitals--Australia--Administration.

Public hospitals--Australia--Cost of operation.

Hospital trustees--Australia.

Other Authors/Contributors:

Centre for Independent Studies (Australia), issuing body.

Dewey Number: 362.110994

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CIS Policy Monograph 137

THE CENTRE FOR INDEPENDENT STUDIES

2013

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ACKNOWLEDGEMENT

Thanks to David Gadiel for providing helpful comments on an earlier draft.
All errors are the responsibility of the author.

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Executive Summary

Public hospitals are a critical part of Australia's health care system and its single most expensive component. While generally regarded as delivering excellent health care, there are serious concerns about the cost, efficiency and productivity of the public hospital sector.

Over the last decade, real (adjusted for inflation) recurrent expenditure on public hospitals increased by 77.5%, with all jurisdictions recording substantial rises. Since 2001–02, the average annual national expenditure growth rate of 7.75% has far exceeded the general rate of inflation, and the cost of public hospital care has grown more than twice faster than national income over the period.

Australia will face problems funding its public hospital and other publicly funded health services if cost increases continue at the current rate in the context of ever-increasing use and an ageing population. The challenges of sustainably financing the cost of health will be exacerbated by inefficiencies in the public hospital sector—unless productivity improvements reduce the quantity of public resources consumed by public hospitals.

Medicare (Australia's 'free,' universal, taxpayer-funded national health scheme) obliges public hospitals to provide hospital care to all Australians without user charges in return for government funding. The absence of market disciplines accounts for the Productivity Commission's finding that productivity is generally superior in Australia's private for-profit hospitals compared to Australia's public hospitals.

Fully addressing the structural problems that constrain the ability of public hospitals to contain costs and increase outputs requires fundamental reform of Medicare. This report identifies and discusses some of the major governance issues that impede public hospital performance and that can be revised within the existing Medicare framework via state government-initiated reforms, principally by adopting quasi market-based initiatives.

Governance problems that impede good management and affect productivity stem from the flawed relationship between local hospitals and central agencies. Australian public hospitals are run as branch offices of state and territory health departments, and are micromanaged by departmental bureaucrats.

The 'command and control' public monopoly model of hospital governance and service delivery features a centralised setting of policies that includes state-wide, union-negotiated industrial agreements (especially for nurses) which also entrenches poor work practices. Frontline managers are expected to meet centrally mandated KPIs, but have limited managerial prerogatives and little ability to overcome workplace rigidities. Lack of control over the clinical workforce, in particular, is inimical to cost-effective management and efficient delivery of quality hospital care.

Devolution of responsibility to the local level has been a policy goal articulated for many years by state and federal politicians, but hospital management has remained highly centralised despite periodic and repeated redesigns of administrative arrangements. State health departments continue to function as 'system managers' with high levels of involvement in the operational affairs of hospitals because financial risk for hospital budget overruns continues to be carried by state treasuries.

Alternative governance arrangements for public hospitals can address existing management problems and also mimic the key factors that international studies show account for better management and superior hospital performance.

The Foundation Trust hospital management and service provision model was introduced into the National Health Service (NHS) in England by the Blair Labor government.

Foundation Trusts combine true managerial independence with genuine financial accountability. Trust hospital boards of directors and CEOs are responsible for managing the hospital's budget, setting the employment terms and conditions of staff, and overseeing all other operational matters. Trusts have the right to borrow funds based on the hospital's capacity to repay out of earnings, and can retain and reinvest surpluses. They can also become insolvent, and sanctions to deter financial mismanagement include the removal of the board.

Adapting the Trust model to the Australian health system will transform the role of central agencies and the relationship with local hospitals by establishing a purchaser-provider split. Instead

of acting as both funder and provider of hospital services as under the existing public monopoly model, health departments will be responsible for negotiating service agreements and contracts with Trusts.

Crucially, Trust hospital boards and CEOs will have the managerial authority to negotiate enterprise agreements with staff that take local conditions and financial realities into account. Workplace flexibility will eliminate restrictive and inappropriate 'one size fits all' industrial agreements, and facilitate the implementation of innovative ways of delivering cost-effective services—a process encouraged by the incentives created by financial accountability.

Improving the performance of public hospitals by placing them under the control of Trust-style boards of management—especially if 'corporatisation' is complemented by a broader microeconomic reform agenda encompassing competitive pricing and selective privatisations—would help control the escalating health expenditure and substantially contribute to the long-term sustainability of the health system as demand rises and population ages.

Introduction

Approximately 30% of total national health care expenditure of $140 billion (or 9.5% of GDP) is expended on Australia's 736 public acute hospitals.[1] The cost of public hospital care now totals over $40 billion a year, and is growing well above the inflation rate. Over the last decade, the average annual growth has been 7.75% compared to an average general rate of inflation of around 3%. Over the same period, real (adjusted for inflation) average GDP grew by only 3.1%, meaning the cost of public hospital care grew more than twice faster than GDP. [2]

Since 2001–02, recurrent expenditure on public hospitals has increased by over 77% in real terms (see Table 1). Over 91% of recurrent funding is provided by federal, state and territory governments, and represents over one-third of total public spending on health. All states and territories have recorded substantial increases, led by 126.4% increase in the Australian Capital Territory and 120% increase in Queensland, followed by doubling of recurrent spending in Western Australia and substantially above the national average increases in Tasmania and the Northern Territory. The cost of the public hospital systems in South Australia has risen roughly in line with the national average, while expenditure in NSW and Victoria has increased by slightly above and below 60%, respectively. In all jurisdictions, health—principally the cost of public hospital care—accounts for around 30% of state and territory budget outlays.

Table 1: Increase in recurrent expenditure on public hospitals, 2001–12 (constant dollars)

	2001–02	2010–11	Increase %
NSW	$7.9	$12.9	63.2
VIC	$6.1	$9.7	59
QLD	$3.5	$7.7	120
WA	$2.1	$4.3	104.7
SA	$1.8	$3.2	77.7
TAS	$0.477	$0.916	92
ACT	$0.412	$0.933	126.4
NT	$0.308	$0.568	84.4
Aust	$22.7	$40.3	77.5

Source: Productivity Commission, *Report on Government Services 2013*, Table 10A.1.

Australia will have problems funding its public hospital and other health services if cost increases continue at the current rate.

Australia will have problems funding its public hospital and other health services if cost increases continue at the current rate. We face the dual challenges of ever-increasing utilisation of publicly funded health services and an ageing population.[3] Substantial increases in government health expenditure in coming decades are projected by the federal government's *Intergenerational Reports*, and rising health costs are set to be primarily responsible for placing large financial pressures on government budgets.[4] The challenges of sustainably financing health care costs will be exacerbated by inefficiencies in the public hospital sector. Conversely, financial challenges will be lessened by productivity improvements that reduce the quantity of public resources consumed by public hospitals.

* Sixty percent of hospital separations take place from public hospitals and 40% from private hospitals. Twice as much elective surgery takes place in the private sector, and the public sector is responsible for more medical care and the vast majority of emergency inpatient care. Public hospitals in some jurisdictions continue to provide a range of specialist ambulatory (outpatient) services.

Studies by the Productivity Commission suggest that the costs of Australia's public and private hospitals are similar when the different casemixes* are taken into account, although there were some data limitations undermining the strength of this conclusion.[5] However, the Costello Commission of Audit recently found that while expenditure on Queensland public hospitals had 'increased 43% between 2007–08 and 2011–12, activity increased by less than half (by only 17%)..[6] This strongly suggests that public hospitals are like other public sector monopolies, and that additional inputs do not produce a proportional increase in output.

This assertion is supported by other evidence of inadequate emphasis on cost control and inferior productivity in the public sector, as compared to the private sector. Julie Novak and Asher Judah's 2011 report for the Australian Centre for Health Research (ACHR), *Towards a Health Productivity Reform Agenda for Australia*, concluded (based on an analysis of casemix-adjusted separations per FTE staff and casemix-adjusted separations per bed) that both labour and capital productivity were higher in private than in public hospitals.[7] The Productivity Commission study also suggested that while all hospitals have the potential to increase their output by about 10% with current inputs, the mean technical efficiency in for-profit private hospitals was higher than in public hospitals.[8]

Novak and Judah identified a number of features of Medicare that constrain the ability of public hospitals to contain costs and increase efficiency. These factors include the disconnect between financing and using publicly provided health care services; growth in health bureaucracies and additional red tape that displaces additional outputs in favour of extra labour input; and the 'misplaced belief that health is "special," in being immune to the application of market forces, [which] diverts attention away from pursuing productivity gains.'[9]

Public hospitals are like other public sector monopolies, and (that) additional inputs do not produce a proportional increase in output.

Under the terms of the National Healthcare Agreement, state and territory governments are obliged to provide public hospital care to all Australians without user charges as a condition for receiving Commonwealth health funding. Fully addressing the structural problems in the public hospital system would require fundamental reform of Medicare.[10] This report identifies and discusses some of the major governance (or public sector management) issues that impede public hospital performance and that can be revised within the existing Medicare framework via state government-initiated reforms, principally by adopting quasi market-based initiatives.

This report also examines the characteristics of efficient hospitals, and points out that better management practices and higher productivity are strongly associated with competitive environments, managerial independence, and private ownership, and are also correlated with the quality and effectiveness of hospital services (better health and safety outcomes measured by significantly lower mortality).[11] Alternative governance arrangements—based on the National Health Service (NHS) Foundation Trust hospital management and service provision model used in England—will be proposed as a step towards mimicking the factors that have been shown to account for superior hospital performance. Introducing Foundation Trust-style governance arrangements into the Australian health system—especially if 'corporatisation' is complemented by a broader microeconomic reform agenda encompassing competitive pricing and selective privatisations—has the potential to enhance policymakers' ability to control the escalating costs of public hospitals and deliver more and better hospital services for taxpayers' increasingly scarce health dollars.

Issues affecting cost containment

The issues discussed in this section suggest there are multiple factors in Australia's public hospitals affecting their performance. Many of these factors are a consequence of the flawed relationship between the state and territory health departments and public hospitals, which result in confused and ineffective hospital management. The

following criticisms should not necessarily be interpreted as singling out failures of the managers of any particular public hospital. Identified instead are systemic problems with hospital governance that impede good management, financial accountability, and efficient delivery of quality hospital care.

Central control by health bureaucracies

Australian public hospitals are run as branch offices of state and territory health departments, and under the day-to-day control of departmental bureaucrats, few of whom have had any hands-on experience in managing a hospital facility. A large referral public hospital is a complex organisation that requires considerable management expertise. Administrators of even smaller hospitals need an understanding of hospital culture and practice.[12]

Under the existing 'command and control' public monopoly model of hospital management and service delivery, micromanagement of hospitals and centralised setting of policies (especially of industrial agreements) by remote central agencies without reference to individual hospital needs and characteristics is ubiquitous in all jurisdictions. Frontline managers are expected to meet centrally mandated KPIs, but have limited managerial prerogatives and little ability to overcome workplace rigidities. Lack of authority over the clinical workforce, in particular, is inimical to cost-effective management.[13]

Devolution of management responsibility to the local level has not been achieved despite periodic and repeated redesigns of governance arrangements.

The need for devolution of management responsibility to the local level has been a policy goal articulated for many years by state and federal politicians. Regrettably, in practice, this has not been achieved despite periodic and repeated redesigns of governance arrangements.

The recent Rudd-Gillard government's national health reforms have placed Local Health and Hospital Districts (LHHDs) in charge of hospitals in designated regions under the nominal control of state government-appointed boards of directors. However, under the LHHD structure, health departments remain the 'system managers' and retain high levels of involvement in the operational affairs of hospitals.[14]

The principal reason for continuing with the highly centralised management is that state treasuries carry the financial risk for the operating budgets of public hospitals. Local health agencies, even when statute suggests their boards possess management autonomy, are responsible to health departments whose primary task is to prevent or limit budget overruns (see page 7).

Health departments therefore play major roles in appointing CEOs. The single most important function of a board of directors should be appointing a CEO. When this responsibility shifts elsewhere, the board's authority is compromised. As a result, hospital boards often function as little more than advisory committees with little real authority over service planning and provision. CEO and board appointment processes are also prone to being politicised, with appointments determined based on loyalty to the government of the day instead of merit.

Excessive centralisation also contributes to high turnover of senior management in the public hospital sector. Flight to the private sector is often linked (anecdotally) to the frustration experienced by public sector CEOs forced to endure interference in management by health department bureaucrats and (sometimes) ministers' offices. Though the management challenges are different in the 'free' public system compared to the private sector, the loss of talented executives and corporate knowledge is inimical to effective management and improved performance, as initiating and embedding reforms to hospital practices generally requires an extended tenure by an experienced CEO.

The hierarchical management structure of the public sector also influences the performance of middle managers such as nurse unit managers who have direct and ongoing responsibility for frontline staff. The autonomy of such staff is crucial in

hospital performance.[15] There is also a strong correlation between staff satisfaction and performance.[16]

Poor work practices

Many restrictive work practices that impede the efficient operation of public hospital facilities arise from industrial agreements between health departments and powerful trade unions. These include the Australian Medical Association; other industrial associations such as the Australian Association of Anaesthetists and the Australian Nursing Federation; and various medical scientists and allied and ancillary health industrial organisations (including the Health Services Union).

Three of the most glaring examples of inefficiency linked to workplace rigidities concern surgical throughput, nurse-to-patient ratios, and demarcation of clinical roles.

Anecdotal accounts suggest surgeons can perform substantially more equivalent work in an operating room session in a private hospital than in a public hospital. Lengthy downtime between cases in the public sector is attributed to multiple factors, including tea breaks, patients not being prepared on time for transport to the operating room, patients' notes or X-rays being 'lost,' unavailability of porters, slow elevators, and teaching obligations. The private sector cannot afford these delays, and achieving smooth and efficient patient throughput is the primary managerial objective. The NSW auditor-general recently reported that thousands more patients could be operated on in NSW public hospitals if theatres ran more efficiently, and attributed the problems to managers lacking the authority to effectively manage patient flow and ensure operations started on time.[17]

Many restrictive work practices that impede the efficient operation of public hospital facilities.

Strict nurse-to-patient ratios of one nurse per four patients are a standard feature of nurse award conditions across Australia. State-wide industrial agreements that mandate staffing levels is poor management and inherently inefficient, but are much loved by nursing unions as they allow the unions to determine the size of the nursing workforce (and expand union membership). Nursing workloads should be determined by hospital managers in consultation with their employees (not the union) based on the strengths and weaknesses of the nursing staff and the mix of patients. Nurse-to-patient ratios exacerbate staff shortages, raise costs, and limit patient throughput because inefficiently using a hospital's nursing workforce limits the number of beds available.

Under the terms of their contract, visiting medical officers and medical staff specialists can treat private inpatients in public hospitals. Admitting rights are widely viewed as essential to attract specialists to work in public hospitals. Use of public facilities is an important source of salary supplementation at considerable public expense, including, for example, care of private patients by resident medical staff.

Private patients account for approximately 10% of total national public hospital admissions each year. This includes emergency admissions, patients who turn out to be compensable by road traffic insurance, workers compensation or tort liability, patients needing access to infrastructure, and staff not available in the private sector. Whereas private treatment in public hospitals is a complex issue, the current system is opaque. If the salaries of visiting medical officers and staff specialists are inadequate, these should be renegotiated based on commercial and industrial realities rather than supplemented by processes that lack accountability. Individual output-based contracts that specify the amount of private work to be undertaken would vastly improve the transparency of the system. Remunerating doctors on a performance basis could also help reduce public elective surgical waiting lists.

Demarcation issues also stymie productivity. Task-substitution and redeployment of the clinical workforce is prohibited because industrial agreements tie the hands of managers seeking flexible, innovative and efficient ways to deliver hospital care. For example, not all the workload of junior resident medical staff requires a medical

degree, but staff with lesser qualifications (and lower salary) cannot undertake these tasks even though this would not affect the quality of patient care or compromise medical training. Similar inefficiencies are apparent in nursing (and in some allied health fields), though this has been lessened by the introduction of TAFE-trained nursing assistants to complement the three-year university trained registered nurse workforce.

Financial unaccountability

The major reason for the public sector's apparent lack of attention to financial management and cost control is the historical practice of dealing with hospitals that overrun their budgets. Standard practice is for additional allocations to be made by Treasury to cover operating deficits accrued during the financial year. Unless local agencies are truly financially accountable, there is no real requirement for boards and senior executives to exert proper control over hospital finances. Genuine independent management and freedom from inappropriate meddling in daily activities by central health agencies is also impossible.

Private for-profit hospitals are accountable to their shareholders and boards, and CEOs will not have a long tenure if there are recurrent deficits and no commercially acceptable return produced on capital expenditures. The not-for-profit private sector would be better called the 'Not For Loss' sector as these operators often rely on profits for capital expenditure, and few 'owners' in this sector are prepared or able to bail out loss-making facilities. Financial accountability and incentives are different in the for-profit and not-for-profit sectors. However, both operating environments empower frontline managers to manage hospital facilities with a focus on cost and performance, which is foreign to the management culture of public hospitals.

The productivity gap between public and private hospitals is not surprising. Few public hospitals have clinical costing systems that allow the cost of treating each patient to be carefully calculated and compared with income. Effective management is difficult without knowing where the profits and losses are. In the private sector, such information is regarded as essential for proper financial control, but less so in the public sector assured of recurrent funding and access to 'free' public capital. The National Health and Hospital Reform Commission (NHHRC) identified a 10% to 20% gap in costs between the least efficient and most efficient public hospitals.[18] Lack of measuring costs makes it difficult to establish the more efficient practices that could be implemented in less efficient hospitals.

The productivity gap between public and private hospitals is not surprising.

Instead of focusing on ways to increase *outputs*, the focus in the public sector is often on managing multiple *inputs*. In addition to major state-government funding streams, whether activity-based or on a population-based formula, most hospitals have multiple additional and largely Commonwealth-funded programs that bring funding to hospitals for specific activities (improving emergency room functions, reducing waiting lists, caring for Indigenous Australians). Each of these will have its own reporting requirements. CEOs cite the increased workload from such activities, probably one factor in the increase in hospital administrative staff noted by Novak and Judah.[19] This also adds to head office overheads, as dedicated staff in the health bureaucracy are required to read (perhaps) and file reports.

Five indicators of a well-managed hospital

Australian public hospital governance does not compare well to best international management practice. A 2010 cross-country study undertaken by McKinsey and the London School of Economics examined the characteristics of efficient, well-managed hospitals. The *Management in Healthcare* report, which evaluated hospitals in Europe (including the United Kingdom) and North America, found five characteristics

associated with good hospital management (measured by 'how well hospital operations, performance, and talent were managed'[20]):

1. competition or at least perceived competition in the environment
2. clinically qualified managers (CEOs in Australian terminology)
3. managerial independence
4. scale
5. private ownership.

The authors concluded that two factors explain why a competitive environment drove higher management scores. CEOs are more likely to try harder when faced with competition as the rewards are higher, as are the risks associated with failing to improve productivity and financial performance. Poorly managed hospitals are likely to fail and either close down or be taken over.

Significant opportunities exist for policymakers to augment hospital performance by creating the conditions shown to be associated with better management.

Hospitals with clinically qualified CEOs were better managed, and those that acquired clinically qualified CEOs during the course of the study improved their management performance. Clinically trained managers were found to better understand clinical challenges, could communicate with clinical staff in a common language, and enjoyed greater credibility than non-clinical managers.

Higher performing hospitals had CEOs with higher levels of autonomy—meaning full operational authority and financial responsibility, combined with appropriate accountabilities. The better hospitals devolved decision-making wherever possible to middle managers with direct responsibility for patient care.

Larger hospitals with more than 1,500 EFT (Effective Full Time) staff were the best performers. Hospitals with between 500 and 1,499 staff performed reasonably well, and those with between 100 and 499 performed adequately. However, those with fewer than 100 staff performed particularly poorly.

Privately owned hospitals (including not-for-profits) had higher management scores across all countries studied than those owned and operated by the state. This was attributed to private hospitals being free from public sector restrictions on employment of staff, resource management, and KPI-driven performance management.

The McKinsey study found that while there was considerable variation in hospital performance across countries, more striking was the large variation across hospitals within countries. It concluded that 'the same key factors appear to account for a significant part of the variation in hospital management in each country, namely, competition, scale, skills, autonomy, and ownership.'[21] The key insight and implication was that significant opportunities exist for policymakers to augment hospital performance by creating the conditions shown to be associated with better management.[22]

Alternative governance model

Alternative governance arrangements for Australia's public hospitals have the potential to address existing management problems and meet most of the criteria in the McKinsey/LSE study, particularly with regards to greater competition, managerial autonomy, financial accountability, and workplace flexibility. The Foundation Trust model, which was developed by the Blair Labour government in the United Kingdom, is particularly appropriate for larger hospitals or hospital groups in metropolitan areas and larger regional centres.

Foundation Trust hospitals

The Foundation Trust model of hospital management and service provision was introduced into the NHS in England to:

- give local communities greater control over hospitals and make hospitals more responsive to local needs
- free hospitals from direction by the secretary of state (minister) for health and central government control, and no longer be performance managed by the Department of Health and its core agencies
- encourage innovation and delivery of care in the most efficient way.[23]

Foundation Trusts are community-run, member-based corporations established under a special statute as independent legal entities, with roles and responsibilities set out in a 'term of authorisation.' Trust members (local community representatives, hospital staff, and patients and their carers) elect a board of governors from the members and other relevant bodies (including Primary Care Trusts, local universities, local authorities, and hospital staff). The board of governors then appoint the chair and members of the hospital board of directors, who are responsible for overseeing hospital management including the hiring of a CEO. The board of governors work with the board of directors to ensure that the Foundation Trust acts in a way that is consistent with the term of authorisation but are not involved in the governance or day-to-day running of the hospital. The role of the board of governors in hospital management is limited to selecting a board of directors with appropriate skills (which is less likely to occur in an open election of Trust members).

The Trust model encompasses a broader microeconomic agenda.

A separate, independent national body, Monitor, also established by statute, issues authorisations and reports to Parliament on the performance of Foundation Trusts.[24]

The major source of income for a Foundation Trust hospital is the purchase of its services by Primary Care Trusts (which operate as fund-holders and agents for enrolled populations) according to a national tariff set at activity-based prices as determined by Monitor. The Trust hospital can retain any surpluses to reinvest in the hospital, borrow funds from private and public sources up to a limit based on capacity to repay out of projected earnings, and become insolvent. To deter financial mismanagement, possible sanctions for insolvency include the removal of the board.

Trust hospitals can seek to amalgamate with or take over other hospitals subject to independent approval to ensure competition is not compromised. They are expected to develop partnerships with other health care organisations in their community. The amount of private work undertaken is strictly limited. The fixed assets of the hospital are the property of the Trust but these assets cannot be alienated or disposed off without Monitor's approval.

Foundation Trust hospitals are regularly inspected by the Department of Health's Health Care Commission (as are other NHS hospitals and services) to ensure they achieve, and are expected to exceed, national health care standards and have appropriate ways to monitor safety and quality of care.

The board of directors is responsible for managing the hospital's budget, for setting the terms and conditions of employing staff, and all other operational matters that would normally be devolved to the CEO. The interaction of the board of governors with the board of directors allows local residents, staff and other key stakeholders to participate in decisions about spending and development of services.

The Trust model encompasses a broader microeconomic agenda with a focus on stimulating the entry of private providers into the market for NHS-funded hospital services. In England, Foundation Trusts can contract with the Independent Sector Treatment Centres (ISTC) to provide select procedures at lower prices than NHS hospitals.

Relevance to Australia

The Foundation Trust model is suited in Australia for larger public hospitals or hospital groups with the potential to develop the necessary expertise to function independently. The Australian Institute of Health and Welfare (AIHW) includes 80 hospitals in its category of principal referral hospitals that account for 70% of public hospital separations.[25] Some grouping of hospitals could be advantageous when establishing 'networks' makes clinical and geographical sense and has community support.[26 †]

Determining eligibility for Trust membership may prove difficult, especially for large inner city tertiary referral hospitals (the so-called traditional teaching hospitals) as many do not have a defined community. Membership could perhaps be open to wide eligibility reflecting the extensive referral base. It is important that the trusts not be at risk of staff (and union) capture. Limitations should therefore be placed on staff and staff family membership.

The Trust hospital or hospitals should negotiate with staff enterprise agreements that take local conditions and financial realities into account.

The appointment of the board of directors is one of the attractions of the Foundation Trust model as it allows recruiting an appropriate range of expertise. The size of the board should to be limited to between 7 and 10 members. Trust governors should receive guidelines setting out the required skill mix among board members spanning finance, business, human relations, IT, community engagement, law, health, and academia (particularly given the teaching and research roles fulfilled by larger hospitals). Health professionals should not comprise more than a third of board members. No current or recent staff member should be on the board of directors, and it is better governance practice if the CEO is not a member—he or she should be responsible to the board. The CEO should attend board meetings, and so on occasion should select senior executive and clinical leaders, including the chair of medical staff, to cultivate good working relationships with board members.

The Trust hospital or hospitals should be the employer of staff, and as independent legal entities, should negotiate with staff enterprise agreements that take local conditions and financial realities into account. This will enable hospitals to progressively eliminate restrictive and inappropriate working conditions that had developed from the 'one size fits all' industrial agreements negotiated between unions and state and territory governments. Workplace flexibility will facilitate the implementation of innovative ways of delivering cost-effective services—a process encouraged by the incentives that full financial accountability creates.

Capital expenditure should be funded from surpluses and commercial borrowings. Direct capital grants from the state should be avoided lest the propensity for politicians to use health infrastructure funding to pork barrel encourage inappropriate investments. Trusts should have the ability to seek endowment funds, charitable donations and bequests.

In the United Kingdom, Monitor is responsible for assessing the performance of Foundation Trusts. In Australia, new independent oversight agencies in each jurisdiction may not be needed. The recently established National Health Performance

† Hospital governance is complicated by the geography of states such NSW and Queensland, due to scattered populations and the need to maintain at least some hospital and other health services in smaller and remote communities. Grouping of these hospitals with common management that does not impair individual autonomy and does not compromise the range and quality of hospital services required locally and available in the 'network' may be an achievable goal. However, the distribution of hospital services is a difficult problem to solve. Retention of hospital services and the formation of hospital groups should be subject to necessary trade-offs involved in sound planning that avoids duplication and achieves economies of scale.

Authority (NHPA) could be adapted to regulate and report on Trust performance to each state and territory parliament. Alternatively, the states could choose to set up their own 'monitor.' If the Foundation Trust hospital becomes insolvent or is at serious risk of doing so, the regulator will be required to alert the health department to help install temporary emergency management.

The core responsibility of state health departments will be negotiating service agreements and purchasing contracts with Trusts. Service agreements should be as minimally prescriptive as possible in terms of the range of services included, leaving most of these decisions to those with local knowledge and the good sense of a competent CEO not to have low volume expensive services simply to meet ill-informed demands for all services to be provided locally. Multi-year purchase contracts are also preferable to facilitate sustainable planning of service. Contract prices should initially be determined according to the national activity-based funding system currently being developed by the Independent Hospital Pricing Authority (IHPA). A period of centrally mandated prices will allow Trusts to develop management capabilities and set the stage for introducing competitive contracting and pricing arrangements.

Trust hospitals would operate considerably in a similar manner to the larger not-for-profit private hospitals and hospital groups in Australia.

Incorporating competitive pricing into the Foundation Trust model will transform the relationship between public hospitals and state health departments by establishing a purchaser-provider split. Instead of acting as both funder and provider of hospital services as under the public monopoly model, state health departments will be able to direct custom via service contracts to better performing hospitals and thereby contain expenditure and maximise the state's return on health spending.

Corporatisation

Adapting the Foundation Trust model to the Australian health system would 'corporatise' the governance of public hospitals. Corporatisation is a structural reform strategy commonly employed in other policy areas to increase the efficiency of public sector utilities. It has often been a prelude to privatisation, and may therefore be contentious when applied in the politically sensitive health portfolio.

However, the Trust model would sidestep the privatisation question; in reality, Trust hospitals would operate considerably in a similar manner to the larger not-for-profit private hospitals and hospital groups in Australia, which include Wesley Hospitals (Brisbane), Seventh Day Adventist Hospital (Sydney), Epworth Hospital Group (Melbourne), Cabrini Health (Melbourne), and St John of God Health Care Group (Perth and elsewhere). Many of these operators provide a range of services similar to the traditional tertiary referral teaching hospitals, with the possible exception of major trauma and some very complex medical conditions. They operate under their own boards of management and CEOs, and have limited involvement with state or territory health departments except for compliance with a small number of statutory regulations. They are owned by religious organisations, which have very little expertise in hospital care and have no involvement in the hospital's day-to-day management. Their income comes predominantly from health insurers to treat inpatients. Capital comes from surpluses and donations, and no longer from the owners, who have other demands on any spare cash. The best hospitals have a strong sense of purpose that permeates the organisation and is a key contributing factor to these hospitals being considered among the best in the country.

The suggestion that Trust hospitals would resemble the independently managed not-for-profit hospitals is not without significant reservations, especially in efficiency. Many jurisdictions have a long history of outsourcing the operation of public hospitals to religious organisations, with little evidence of demonstrable financial benefits to the state. In NSW, for example, the Catholic religious organisations manage hospitals that are essentially clones of peer public sector facilities. Data demonstrating superior productivity and cost-effectiveness is not available—and understandably so when

core clinical services are delivered under public sector conditions.[27] The Productivity Commission found that productivity was higher in for-profit than in not-for-profit hospitals, a finding that strongly indicates that ownership is the primary driver of better management and efficiency (as the McKinsey study shows). In fact, the commission's study revealed that not-for-profit performance was on average worse than public hospitals but data was limited.[28]

Recent reform initiatives, however, suggest that not-for-profit operators can deliver value for taxpayers' money under the right conditions. In 2012, the WA government outsourced the construction, operation and maintenance of the new Midland Public Hospital (replacing the Swan District Hospital) to St John of God Health Care for 20 years. The WA Treasury expects the private not-for-profit operator to save the state $1.3 billion over the life of the $5 billion contract compared to the estimated cost of the state delivering the project. This includes discounts on the cost of providing clinical services of between 3.3% and 15%. St John of God Health Care, which operates 13 hospitals across Australia and was appointed operator after an open and competitive tender against for-profit rivals, is required to deliver high quality hospital services at agreed prices that under the terms of the contract are guaranteed to be always less than the equivalent cost for the same services at comparable state-run hospitals.[29]

Foundation Trusts offer the prospect of combining genuine autonomy of hospital management with greater financial accountability and innovation-led productivity improvements.

The Midland privatisation reinforces a key point: Revised governance arrangements are not a complete answer to the public hospital conundrum. Foundation Trusts offer the prospect of combining genuine autonomy of hospital management with greater financial accountability and innovation-led productivity improvements. But the impact on productivity is likely to be limited unless accompanied by a broader microeconomic reform agenda that includes a genuine purchaser-provider split and the creation of a contestable market for public hospital care.

This is supported by analyses of the impact of Foundation Trusts in England. A 2010 review of Trust performance by the think tank Civitas concluded that while Trusts have generally performed well financially, and generated surplus while maintaining high quality standards, the 'surpluses have been modest in relation to total revenue' and with little evidence of major innovations. Significantly, lack of large-scale cost reductions was not attributed to the failure of market-based reform, but to reforms not going far enough to increase competition and stimulate the entry of non-NHS private providers.[30] The lesson from the Trust experiment in England is that 'corporatising' the governance of public hospitals should be supplemented by selective use of privatisation to introduce greater competition into the sector and maximise potential efficiency gains.

Privatisation

The impact of financially accountable and managerially independent Foundation Trusts on the cost of public hospital care can be enhanced by the greater involvement of private operators in delivering public hospital care. As David Gadiel and Jeremy Sammut[31] have argued, state governments should further encourage adopting market and private sector methods by using Privately Financed Projects (PFPs).

PFPs (as in the case of the Midland Hospitals) involve contracting out full managerial responsibility and financial risk for operating public hospitals onto private operators. The existing public sector monopoly is thereby replaced with a more contestable market for public hospital care. Allowing central agencies to purchase hospital services from competing private providers is designed to spur the public hospitals that remain in state hands to improve their performance by imitating the best practice, 'business-like' methods of more efficient privately operated hospitals.

PFP hospitals have the potential to play an analogous role in Australia to the ISTC providers in England, and introduce greater market disciplines and consumer focus into the public hospital sector. State health departments could also enter into

spot or specific volume contracts with private hospitals to provide elective care and specific clinical services to public patients.[32] Similarly, Trusts should be obliged to seek competitive tenders from private providers for some clinical and other services to test their efficiency.

The PFP model may be more applicable initially to smaller public hospitals, and new and redevelopment hospital projects, than a large teaching hospital. The difficulties in drawing up contracts for teaching hospitals, with their wide range of services and mix of outputs—including clinical care, community education, teaching and research—would be considerable. However, the same challenges will need to be addressed to establish proper purchasing contracts with Foundation Trusts. Once central agencies develop these capacities, the use of PFPs to privatise teaching hospitals can be further explored.

Conclusion

There are substantial problems in the governance arrangements of Australian public hospitals. These include micromanagement by state and territory health bureaucracies (and at times by minister's offices), poor work practices, ineffective cost control, and onerous reporting requirements. These deficiencies lead to poor morale and job satisfaction, which further impair efficiency. That most public hospitals still deliver quality care is a tribute to their clinical staff and frontline managers. Overarching governance problems are a case of 'system failure' that adds substantially to the total cost of health to Australian governments.

The Foundation Trust model is an attractive and politically viable alternative to the status quo. It has the potential to address many of the governance and management problems identified in this report, and in those of Gadiel and Sammut and Novak and Judah. There are many skilled hospital managers in our community who would welcome the chance to work in the public hospital sector under a governance framework that combines real managerial independence and genuine financial accountability, and offers opportunities to achieve sustainable reform in partnership with appropriately qualified hospital boards.

We urge state and territory governments to trial the Foundation Trust model in a range of their hospitals to demonstrate its superiority to the existing public monopoly model. The overarching goal should be to remove state and territory health departments from any direct role in hospital management over a 7- to 10-year transition period. Devolution of hospital management should substantially reduce the size of health bureaucracies and allow central agencies to focus on appropriate policy functions. These functions include regulating safety and quality standards, but must also include developing the skills to negotiate contracts with Trusts and other providers. This is to emphasise that establishing Trust-style hospitals is only the first step towards preparing the public health system for a new era of competitive hospital service delivery, based on price contestability and the entry of private operators into the sector.

Establishing Trust-style hospitals is only the first step towards preparing the public health system for a new era of competitive hospital service delivery.

Health care is consuming an increasing proportion of government budgets, and will absorb substantially higher proportions of national income in coming decades. Given that public hospitals are the most costly single component of public health services, we can no longer afford to quarantine these services from overdue reforms. Improving the performance of the public hospital sector by placing them under the control of community Trusts as part of a broader microeconomic reform agenda would make a substantial contribution to the long-term sustainability of the health system as demand rises and population ages.

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CIS Policy Monograph • PM137 • ISSN: 0158 1260 • ISBN: 978 1 922184 21 4 • AU$9.95
Published September 2013 by The Centre for Independent Studies Limited. Views expressed are those of the authors and do not necessarily reflect the views of the Centre's staff, advisors, directors or officers.

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